in § 413.24 of this chapter to determine the actual cost of these covered services.

(d) *Supplier services furnished directly by the HMO or CMP.* If the HMO or CMP furnishes Part B physician and supplier services directly, it must furnish statistics that indicate the frequency and type of service provided, in the form and detail prescribed by CMS.

(e) *Part B physician and supplier services furnished through arrangement.* If the HMO or CMP furnishes Part B physician and supplier services under arrangements with others, it must furnish to CMS statistical, financial, and other information with respect to those services in the form and detail prescribed by CMS.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46231, Sept. 6, 1995]

§ 417.570 Interim per capita payments.

(a) *Principle of payment.* (1) CMS makes monthly advance payments equivalent to the HMO's or CMP's interim per capita rate for each beneficiary who is registered in CMS records as a Medicare enrollee of the HMO or CMP.

(2) Additional lump-sum payments may be made at other times during the contract period, at CMS's discretion, to adjust the total amounts paid during the contract period to the level of incurred costs.

(b) *Determination of rate.* The interim per capita rate of payment is equal to the estimated per capita cost of providing covered services to the HMO's or CMP's Medicare enrollees, based upon the types and components of costs that are reimbursable under this part. The interim per capita rate is determined annually by CMS on the basis of the HMO's or CMP's annual operating and enrollment forecast (as set forth in § 417.572) and may be revised during the contract period as explained in paragraphs (c) and (d) of this section.

(c) *Adjustments of payments.* In order to maintain the interim payments at the level of current reasonable costs, CMS will adjust the interim per capita rate, to the extent necessary, on the basis of adequate data supplied by the HMO or CMP in its interim estimated cost and enrollment reports or on other evidence showing that the rate based on actual costs is more or less than the current rate. Adjustments may also be made if there is—

(1) A change in the number of Medicare enrollees that affects the per capita rate;

(2) A material variation from the costs estimated when the annual operating budget was prepared; or

(3) A significant change in the use of covered services by the HMO's or CMP's Medicare enrollees.

(d) *Reduction of interim payments.* If the HMO or CMP does not submit, on time, the reports and other data required to determine the proper amount of payment, CMS may reduce interim payments to the extent appropriate, or may take any other action authorized under this part. An interim payment reduction remains in effect until CMS can make a reasonable estimate of per capita costs.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993]

§ 417.572 Budget and enrollment forecast and interim reports.

(a) *Annual submittal.* The HMO or CMP must submit an annual operating budget and enrollment forecast, in the form and detail required by CMS, at least 90 days before the beginning of each contract period. The forecast must be based on financial and statistical data and records that can be verified if CMS requires a detailed review of supporting records. The data and records include, but are not limited to, all ledgers, books, records, and original evidence of costs, and statistical data used in the determination of reasonable cost.

(b) *Effect of failure to submit on time.* If the HMO or CMP does not submit the budget and enrollment forecast on time, CMS may—

(1) Establish an interim per capita rate of payment on the basis of the best available data and adjust payments on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or

(2) If there is not enough data on which to base an interim per capita